

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 182

08570

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKS</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XI ROCKS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha Julia Amos</u>				4. DATE OF DEATH Month Day Year <u>August 19 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 27 1878</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>22</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Not Known</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs Wm Crockett, Rocks Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>331X</u> (c) <u>—</u> DUE TO (a) <u>—</u> (b) <u>—</u> (c) <u>—</u> causing the underlying cause listed.						INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Bel Air Md. 8-19-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 21 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Street Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm M. Knut</u>				ADDRESS <u>Sanctaville</u>		24a. REC'D BY REGISTRAR DATE <u>8-23-57</u>	
						24b. REGISTRAR'S SIGNATURE <u>Priscilla Lownd</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
AUG 27 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

08546

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08551

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen,		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Royal Ave.		d. STREET ADDRESS R D 1 Port Deposit 07x2.2	
3. NAME OF DECEASED (Type or print) First Raymond Lee Middle Campbell Last 		4. DATE OF DEATH Month August Day 15 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-06
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY contractor	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter C. Campbell		14. MOTHER'S MAIDEN NAME Bessie Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 220-18-7202	
17. INFORMANT Ethel Campbell, Port Deposit, Md. RD.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Gerald C Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bell Air, Md. DATE SIGNED 8-15-57	
EXAMINER'S NAME (Type) Gerald C. Palmer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		8-15-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-18-1957	
22c. NAME OF CEMETERY OR CREMATORY Asbury		22d. LOCATION (City, town, or county) (State) Port Deposit, Md., RD 1	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md.		24a. REC'D BY REGISTRAR Aug 16/57	
ADDRESS Perryville, Md.		24b. REGISTRAR'S SIGNATURE Ellie G. Perry	

AUG 19 1957

CERTIFICATE OF DEATH

Reg. Dist. No.

185-

b. COUNTY

[Handwritten signature]

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

Year

IF UNDER 1 YEAR	IF UNDER 24 HRS
-----------------	-----------------

Months	Days	Hours	Min.
--------	------	-------	------

12. CITIZEN OF WHAT COUNTRY.

14 MOTHER'S MAIDEN NAME

Address

INTERVAL BETWEEN ONSET AND DEATH	INTERVAL BETWEEN ONSET AND RECOVERY	INTERVAL BETWEEN ONSET AND RECOVERY
1-2	1-2	1-2
3-4	3-4	3-4
5-6	5-6	5-6
7-8	7-8	7-8
9-10	9-10	9-10
11-12	11-12	11-12
13-14	13-14	13-14
15-16	15-16	15-16
17-18	17-18	17-18
19-20	19-20	19-20
21-22	21-22	21-22
23-24	23-24	23-24
25-26	25-26	25-26
27-28	27-28	27-28
29-30	29-30	29-30
31-32	31-32	31-32
33-34	33-34	33-34
35-36	35-36	35-36
37-38	37-38	37-38
39-40	39-40	39-40
41-42	41-42	41-42
43-44	43-44	43-44
45-46	45-46	45-46
47-48	47-48	47-48
49-50	49-50	49-50
51-52	51-52	51-52
53-54	53-54	53-54
55-56	55-56	55-56
57-58	57-58	57-58
59-60	59-60	59-60
61-62	61-62	61-62
63-64	63-64	63-64
65-66	65-66	65-66
67-68	67-68	67-68
69-70	69-70	69-70
71-72	71-72	71-72
73-74	73-74	73-74
75-76	75-76	75-76
77-78	77-78	77-78
79-80	79-80	79-80
81-82	81-82	81-82
83-84	83-84	83-84
85-86	85-86	85-86
87-88	87-88	87-88
89-90	89-90	89-90
91-92	91-92	91-92
93-94	93-94	93-94
95-96	95-96	95-96
97-98	97-98	97-98
99-100	99-100	99-100

61	19. WAS AUTOPSY
----	-----------------

PERFORMED?
YES ☐ NO ☒

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

(County)

PHYSICIAN'S NAME (Type) Edward C. Loo, M.D. Hawthorne Grace, Ind.

2d LOCATION (City, State, Zip)

24. REGISTRAR'S SIGNATURE _____

248. REGISTRAR'S SIGNATURE
G. L. Davis, Jr.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

<p>NAME OF DECEASED</p>		<p>AGE</p>		<p>SEX</p>		<p>RACE</p>		<p>DATE OF BIRTH</p>		<p>DATE OF DEATH</p>	
<p>PLACE OF BIRTH</p>		<p>PLACE OF DEATH</p>		<p>CAUSE OF DEATH</p>		<p>MANNER OF DEATH</p>		<p>EDUCATION</p>		<p>RELIGION</p>	
<p>DATE OF INTERMENT</p>		<p>PLACE OF INTERMENT</p>		<p>NAME OF INTERMENT SOCIETY</p>		<p>NAME OF MINISTER</p>		<p>NAME OF FUNERAL HOME</p>		<p>NAME OF UNDERTAKER</p>	
<p>DATE OF REPORT</p>		<p>REPORTED BY</p>		<p>REPORTED BY (Signature)</p>		<p>REPORTED BY (Title)</p>		<p>REPORTED BY (Address)</p>		<p>REPORTED BY (City)</p>	
<p>DATE OF RECEIPT</p>		<p>RECEIVED BY</p>		<p>RECEIVED BY (Signature)</p>		<p>RECEIVED BY (Title)</p>		<p>RECEIVED BY (Address)</p>		<p>RECEIVED BY (City)</p>	

BUREAU V. S.

AUG 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08553

08548

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>33 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>UNIATA 830 UNIATA ST.</u>	
3. NAME OF DECEASED First <u>MARY</u> Middle <u>-</u> Last <u>DOMINICK</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13-1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MARRIED NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Samuel Dominick, Harford, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive metastasis in the abdomen</u> <u>153X</u> DUE TO <u>adenocarcinoma of the colon (Two lesions)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1</u> , 19 <u>57</u> , to <u>8-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11 PM</u> , 19 <u>57</u> , and that death occurred at <u>12:01 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry H. Kwak</u> M.D.		ADDRESS (Street, city or town, state) <u>Harford Mem. Hospital, Harford, Md.</u>	
PHYSICIAN'S NAME (Type) <u>HENRY H. KWAK</u>		DATE SIGNED <u>8-1-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/3/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Not Given</u>		22d. LOCATION (City, town, or county) (State) <u>Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Dominick</u> ADDRESS <u>Harford, Md.</u>		24a. REC'D BY REGISTRAR <u>8-2-57</u>	
24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>			

BUREAU V. S.

AUG 5 1957

RECEIVED

08549

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hernesda Race</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ed #2 07X1.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Baltimore Memorial Hospital</u>		d. STREET ADDRESS <u>Rising Sun</u>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>J.</u> Last <u>Durham</u>		4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/18/1902</u>
9. AGE (In years lost birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steam Boiler</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Durham</u>		14. MOTHER'S MAIDEN NAME <u>Larsh Tuckeren</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>183-05-5937</u>	
17. INFORMANT <u>Mrs. Katherine Durham</u>		Address <u>Rising Sun, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Posterior lateral Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with myocardial infarction</u> (c) <u>Arteriosclerotic Cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombophlebitis - right lower extremity</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 22nd 1957</u> to <u>Aug 27th 1957</u> that I last saw the deceased alive on <u>Aug 27th 1957</u> and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Too, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Rising Sun, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Too, M.D.</u>		DATE SIGNED <u>8/27/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 31/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cr. Rising Sun, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u>		ADDRESS <u>Rising Sun, Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Dr. L. Lewis</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1957

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Date of birth</p>		<p>4. Date of death</p>	
<p>5. Place of birth</p>		<p>6. Place of death</p>	
<p>7. Cause of death</p>		<p>8. Manner of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Date of registration</p>		<p>12. Date of filing</p>	

RECEIVED
 MAY 30 1957
 BUREAU V. M.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08550
CERTIFICATE OF DEATH

08555

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Texas c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford Dallas			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b -			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital				d. STREET ADDRESS 7626 Hillard Drive 7 Brothers Trailer Court			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle Tyler Last Erwin				4. DATE OF DEATH Month August Day 6 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 6, 1957	
9. AGE (In years last birthday) yrs. 9		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Travis Herman Erwin		14. MOTHER'S MAIDEN NAME Priscilla Anne Hahn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Father		Address As in 2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Prematurity DUE TO - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - DUE TO - (c) -							INTERVAL BETWEEN ONSET AND DEATH -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. -				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Aberdeen				20g. (County) Harford		20h. (State) Texas	
21. I certify that I attended the deceased from August 6 , 19 57 , to August 6 , 19 57 , that I last saw the deceased alive on August 6 , 19 57 , and that death occurred at 9:45p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George C. Santos				M.D. US Army Hospital			
PHYSICIAN'S NAME (Type) GEORGE C. SANTOS, CAPT, MC.				ADDRESS (Street, city or town, state) Aberdeen Proving Ground, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug 9th 1957		22c. NAME OF CEMETERY OR CREMATORY Post Cemetery	
22d. LOCATION (City, town, or county) Aberdeen Proving G. Md				22e. (State) Texas			
23. FUNERAL DIRECTOR'S SIGNATURE John G. Sarbing				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR Aug 12-57	
24b. REGISTRAR'S SIGNATURE Mellie G. Perry							

2050171XVI

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness	
John Doe		45		Male		White		1912		Boston, Mass.		Boston, Mass.		Heart Disease		Natural		Teacher		High School		Roman Catholic		Married		August 10, 1957		10:30 AM		Home		Dr. J. A. Smith		Mr. J. B. Jones		Mrs. J. C. Doe		Mr. J. D. Smith	
John Doe		45		Male		White		1912		Boston, Mass.		Boston, Mass.		Heart Disease		Natural		Teacher		High School		Roman Catholic		Married		August 10, 1957		10:30 AM		Home		Dr. J. A. Smith		Mr. J. B. Jones		Mrs. J. C. Doe		Mr. J. D. Smith	

BUREAU V. 8

AUG 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08551

CERTIFICATE OF DEATH

08556-

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> 24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>802 Harfield Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Richard First Calver Middle</u> <u>Baby Boy Gamble (#2)</u>		DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 4, 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Clifton Gamble</u>		14. MOTHER'S MAIDEN NAME <u>Ida Mae Giles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Robert C. Gamble</u>		Address <u>802 Harfield Rd. Harre de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY PULMONARY ATLECTASIS</u> 762.5 DUE TO <u>PolyHYDRAMNIOS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost s/he the deceased alive on <u>August 4</u> , 19 <u>57</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Wolbert</u> M.D.		ADDRESS (Street, city or town, state) <u>200 NORTH UNION AVE</u> DATE SIGNED <u>8/4/57</u>	
PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT MD</u>		<u>HARRE DE GRACE MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-5-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Meth Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Bullock</u>		ADDRESS <u>Harre de Grace Md.</u>	
24a. REC'D BY REGISTRAR <u>8-5-57</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis m. l.</u>	

2271268XVI

BUREAU V. 2

AUG 7 1957

RECEIVED

1
M
C
71
I
0

TO MEDICAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08552

CERTIFICATE OF DEATH

08552

Reg. Dist. No.

183

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>802 Garfield Road</u>	
3. NAME OF DECEASED (Type or print) <u>Russell Baby Boy</u> First <u>Calvin</u> Middle <u>Allen</u> Last <u>Gamble</u>		4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-4-57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Gamble</u>		14. MOTHER'S MAIDEN NAME <u>Ida Mae Giles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robert Gamble - Father</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY & PULMONARY ATALACTASIS</u> DUE TO <u>762.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>POLYHYDRAMNIOS</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>Aug. 4</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Wolbert MD</u>		ADDRESS (Street, city or town, state) <u>200 NORTH VINEYARD AVE</u> DATE SIGNED <u>AUGUST 4, 1957</u>	
PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT MD</u>		<u>HARRE DE GRACE MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-5-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Meth Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia S. Buller</u>		ADDRESS <u>Harre de Grace, Md.</u>	
24a. REC'D BY REGISTRAR <u>8-5-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis, M.D.</u>	

2171267XVI

18

BUREAU V. S.

406 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08553

CERTIFICATE OF DEATH

08558

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u> 30 yrs.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harve de Grace</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hosp</u>				d. STREET ADDRESS <u>846 Locust St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Grimes</u> Last <u>Grimes</u>				4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-29-1924</u>	
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookery Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Firework Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Harve de Grace</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William Grimes</u>				14. MOTHER'S MAIDEN NAME <u>Florence Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-22-6730</u>		17. INFORMANT <u>Mrs. Florence Grimes - Harve de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 Hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>No</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>12/10</u> , 19 <u>54</u> , to <u>8/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/24</u> , 19 <u>57</u> , and that death occurred at <u>4:55 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Stansbury</u> M.D.				ADDRESS (Street, city or town, state) <u>529 Revolution St. Harve de Grace, Md.</u>			
DATE SIGNED <u>8/24/57</u>							
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				ADDRESS <u>Harve de Grace, Md.</u>			
22b. DATE THEREOF <u>8-27-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James G.M.E. Cemetery</u>		22d. LOCATION (City, town, or county) <u>Harvey Hill, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelis S. Bullock - Harve de Grace, Md.</u>				24a. REC'D BY REGISTRAR <u>G. L. Lewis M.D.</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>8-26-57</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

AUG 28 1957

RECEIVED

08554

CERTIFICATE OF DEATH

Reg. Dist. No.

0855985

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun Rural</u>	
c. LENGTH OF STAY IN 1b <u>30 hrs.</u>		d. STREET ADDRESS <u>07x22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard Hamilton Guthrie</u>		4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 10, 1926</u>
9. AGE (In years lost birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Press Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fiber Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Warren Smith</u>		14. MOTHER'S MAIDEN NAME <u>Iva Mae Bollen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>217-40-416</u>	
17. INFORMANT <u>Rosie Guthrie</u>		Address <u>Rising Sun, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Heart Disease</u> DUE TO (b) <u>Pulmonary Edema</u> (c) <u>Severe Mitral Stenosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 mo.</u> <u>3 days</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>8/4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/4</u> , 19 <u>57</u> , and that death occurred at <u>8 P</u> .M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, MD</u> DATE SIGNED <u>8/6/57</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u>		<u>Rising Sun, MD</u> <u>8/6/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Aug 7, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Friends Burial Ground</u>	22d. LOCATION (City, town, or county) (State) <u>Rising Sun, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Syron</u> ADDRESS <u>Rising Sun, MD</u>		24a. REC'D BY REGISTRAR <u>Dr. A. L. Lewis</u>	24b. REGISTRAR'S SIGNATURE <u>Dr. A. L. Lewis</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 2 511

RECEIVED

08571

CERTIFICATE OF DEATH

08560

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Madonna (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rutledge, Fallston RD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice Katherine Hanlon</u>				4. DATE OF DEATH Month Day Year <u>Aug 24 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31, 1892</u>		9. AGE (In years last birthday) <u>65 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Rutledge Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Hanlon</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Dalton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>George L. Hanlon Fallston RD Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 CORONARY occlusion.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY sclerosis.</u> DUE TO (c) <u>HYPERTENSIVE-ARTERIOSCLEROTIC Heart Disease.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>18 Hours</u> <u>5 years</u> <u>20 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Enlargement.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/10</u> , 19 <u>57</u> , to <u>8/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/24</u> , 19 <u>57</u> , and that death occurred at <u>10 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. James Thomison, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Janettsville, Maryland.</u>			
PHYSICIAN'S NAME (Type) <u>S. JAMES THOMISON, JR., M.D.</u>				DATE SIGNED <u>Janettsville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug 28, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Catholic</u>		22d. LOCATION (City, town, or county) (State) <u>Hyde Batts Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin L. Kutz Janettsville Md</u>				24a. REC'D BY REGISTRAR <u>DATE 8-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>Prueella Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU OF HEALTH

JUN 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08555

CERTIFICATE OF DEATH

Reg. Dist. No.

08561

185-

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		d. STREET ADDRESS <u>510 Jennette St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary Ellen</u> Middle <u>Harbuck</u> Last <u>Harbuck</u>				4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/17/1894</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland - North East</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wharton - ? deceased</u>				14. MOTHER'S M maiden name <u>(deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Name <u>Howard H. Hawke</u> Address <u>Harre de Grace, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 5</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. J. Simon</u> M.D.				DATE SIGNED <u>August 5, 1957</u>			
PHYSICIAN'S NAME (Type) <u>E. J. SIMON</u>				ADDRESS (Street, city or town, state) <u>Harre de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8-8-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>North East Meth. Ch. Cecil Co.</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>				ADDRESS <u>Harre de Grace Md</u>		24a. REC'D BY REGISTRAR DATE <u>8-8-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. R. Lewis m.d.</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. PLACE OF DEATH [Faint text]</p>		<p>10. DATE OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	

BUREAU V. S.

AUG 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08562

08556

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POA Harford Memorial Hospital</u> e. STREET ADDRESS <u>35 Grove St</u> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. STREET ADDRESS <u>35 Grove St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>William Harry</u> First <u>Harry</u> Middle <u>Hoke</u> Last <u>Hoke</u> 4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1957</u>				5. SEX <u>M</u> 6. COLOR OR RACE <u>E</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>1 October 1945</u> 9. AGE (In years last birthday) <u>11</u> IF UNDER 1 YEAR Months <u>11</u> Days <u>18</u> IF UNDER 24 HRS. Hours <u>11</u> Min. <u>18</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William H. Banks</u> 14. MOTHER'S MAIDEN NAME <u>Rachel Hoke</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>William H. Banks</u> Address <u>35 Grove St. Aberdeen, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage due to</u> <u>813X</u> DUE TO <u>Crushing Injury Pelvis</u> Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (a), stating the underlying cause last. DUE TO <u>—</u> (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> <u>Auto accident auto-bicycle type</u> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto-bicycle type</u> 20c. TIME OF INJURY Month, Day, Year <u>8-10-57</u> Hour <u>11</u> o. m. <u>—</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>New County Rd Aberdeen Harford Md</u> 20f. (City or town) <u>Aberdeen</u> (County) <u>Harford</u> (State) <u>Md</u>				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gerald E Palmer</u> EXAMINER'S NAME (Type) <u>Gerald E Palmer</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>8/13/57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u> 22d. LOCATION (City, town, or county) <u>Churchville</u> (State) <u>Maryland</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarning</u> ADDRESS <u>Aberdeen Md</u> 24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis</u> DATE <u>8-13-57</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *John William Smith*
2. Date of Death: *August 10, 1957*
3. Place of Death: *Home*
4. Age: *45*
5. Sex: *Male*
6. Race: *White*
7. Marital Status: *Married*
8. Occupation: *Engineer*
9. Cause of Death: *Myocardial Infarction*
10. Manner of Death: *Natural*
11. Signature of Medical Examiner: *[Signature]*
12. Date of Examination: *August 11, 1957*

BUREAU V. S.

AUG 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08557

CERTIFICATE OF DEATH

Reg. Dist. No.

08563

185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Somerville Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Harlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type and print) First Middle Last <u>Elyahoot Y. Hutchins</u>		4. DATE OF DEATH Month Day Year <u>August 26 19 57</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13 1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retail</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Kinsley</u>		14. MOTHER'S MAIDEN NAME <u>Lathen Alwal</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>100-100000000</u>	
17. INFORMANT <u>Mr M. L. Hutchins</u>		Address <u>Harlington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u> 585X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Common Duct "T"-tube drainage</u> DUE TO <u>Cholecystectomy and Cholelithotomy</u> (c) <u>for gangrenous cholecystitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>17 days</u> <u>"</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8 Aug</u> , 19 <u>57</u> to <u>26 Aug</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>26 Aug</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>W. H. Sadowsky</u> M.D. <u>600 S. Union Av.</u> <u>W. H. SADOWSKY</u> <u>Home de Grace, Md 26 Aug '57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Aug 28, 1957</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Brandywine</u>		22d. LOCATION (City, town, or county) (State) <u>Wilmington Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24a. REC'D BY REGISTRAR <u>Aug 27</u>	
24b. REGISTRAR'S SIGNATURE <u>J. L. Lewis</u>			

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15

BUREAU V. S.

SEP 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08572

08564

Reg. Dist. No. 18

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FALLSTON</u>		c. LENGTH OF STAY IN 1b <u>OVER 10 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FALLSTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RECKORD Rd</u>				d. STREET ADDRESS <u>1 RECKORD Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DELBERT ROBERT JENNINGS</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 29 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 19, 1909</u>		9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BULL DOZER OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES M. JENNINGS</u>				14. MOTHER'S MAIDEN NAME <u>MARY MATILDA HAMPTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>GENE JENNINGS, FALLSTON, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL CONCUSSION</u> <u>812 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CRUSHING INJURY TO HEAD FROM</u> DUE TO (c) <u>KNOCK-DOWN ON PAVEMENT BY AUTOMOBILE</u> </p></div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH <u>ESTIMATE</u> <u>LESS THAN 1 HOUR</u></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>BELIEVE TO HAVE BEEN BACKED OVER AND KNOCKED DOWN BY AUTO</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>12:30 AUG 29 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STREET</u>		20f. (City or town) (County) (State) <u>FALLSTON HARFORD, Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 31, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT ZION</u>		22d. LOCATION (City, town, or county) (State) <u>BELAIR HARFORD, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Benson</u>				24a. REC'D BY REGISTRAR <u>SEP 4 1957</u> REGISTRAR'S SIGNATURE <u>Charles Howard</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08573

CERTIFICATE OF DEATH

Reg. Dist. No.

08565
181

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural HARVE DE GRACE				c. LENGTH OF STAY IN 1b 27 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) JOHN RAYMOND First Middle Last				4. DATE OF DEATH 7-AUG- Month Day Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 MAR. 1907	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER				10b. KIND OF BUSINESS OR INDUSTRY A.P.D.		11. BIRTHPLACE (State or foreign country) VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John McROBERTS				14. MOTHER'S MAIDEN NAME NANNIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Emma H. Roberts-Harvde Grace Md. #2 Address R.D.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema - 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Massive Cerebral Hemorrhage - DUE TO (c) Malignant Hypertension						INTERVAL BETWEEN ONSET AND DEATH 2 hrs - 2 hrs - 10 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May , 19 44 , to Aug 7 , 19 57 , that I last saw the deceased alive on August 7 , 19 57 , and that death occurred at 5:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 North Ann Ave. Harvde Grace Maryland DATE SIGNED 8/7/57							
ACTUAL SIGNATURE Frank Wolbert M.D.				PHYSICIAN'S NAME (Type) FRANK WOLBERT M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		10-AUG-1957		BEL AIR MEMORIAL		BEL AIR MD	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell ADDRESS Harvde Grace Md.				24a. REC'D BY REGISTRAR Aug 9-57		24b. REGISTRAR'S SIGNATURE Hellie K. Perry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

NAME OF DECEASED <i>John W. Williams</i>		DATE OF DEATH <i>Aug 10 1957</i>	
AGE <i>45</i>		SEX <i>M</i>	
RACE <i>W</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Teacher</i>		MARITAL STATUS <i>Married</i>	
PLACE OF BIRTH <i>MD</i>		DATE OF BIRTH <i>Aug 15 1912</i>	
PLACE OF DEATH <i>MD</i>		DATE OF DEATH <i>Aug 10 1957</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		SIGNATURE OF REGISTRAR <i>[Signature]</i>	
DATE OF SIGNATURE <i>Aug 12 1957</i>		DATE OF SIGNATURE <i>Aug 12 1957</i>	

BUREAU V. 1

AUG 12 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08558

CERTIFICATE OF DEATH

08566

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>				c. LENGTH OF STAY IN 1b <u>45 YEARS</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 HAVERDE GRACE</u>				d. STREET ADDRESS <u>115 S. ADAMS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NO</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FAYE</u> Middle <u>ALGER</u> Last <u>MOTT</u>			4. DATE OF DEATH Month <u>AUG</u> Day <u>19</u> Year <u>1957</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 21 1901</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>WEST CHESTER Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John A. HIPPLE</u>				14. MOTHER'S MAIDEN NAME <u>ANNA L. CHANEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>W. RAY MOTT 115 S. Adams St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exhaustion - Carcinoma</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Day - Carcinoma</u> DUE TO (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-21-57</u> to <u>8-21-57</u> , that I last saw the deceased alive on <u>8-21-57</u> , and that death occurred at <u>5-12 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>HARFORD GRACE, Md.</u> DATE SIGNED <u>8-21-57</u>			
PHYSICIAN'S NAME (Type) <u>A. L. Lewis</u>				ADDRESS <u>HARFORD GRACE, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 22 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>		22d. LOCATION (City, town, or county) (State) <u>HAVERDE GRACE Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Harford Grace, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>8-21-57</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>	

CERTIFICATE OF DEATH

PLACE OF BIRTH BALTIMORE, MARYLAND		PLACE OF DEATH BALTIMORE, MARYLAND	
DATE OF BIRTH JAN 15 1900		DATE OF DEATH JAN 15 1957	
SEX MALE		RACE WHITE	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
MARITAL STATUS SINGLE		MEDICAL HISTORY HYPERTENSION	
EDUCATION HIGH SCHOOL		SOCIAL HISTORY NO ALCOHOL, NO TOBACCO	
SIGNATURE OF DECEASED (Faint signature)		SIGNATURE OF WITNESS (Faint signature)	
SIGNATURE OF PHYSICIAN (Faint signature)		SIGNATURE OF CORONER (Faint signature)	
SIGNATURE OF REGISTRAR (Faint signature)		SIGNATURE OF CLERK (Faint signature)	

BUREAU V. S.

AUG 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08559

CERTIFICATE OF DEATH

08567

Reg. Dist. No. 183

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAIRE DE GRACE 204RS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAIRE DE GRACE 24</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>71 HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>317 S Union Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>LOUISE</u> Middle <u>MURPHY</u> Last <u>MURPHY</u>				4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years last birthday) <u>44 80</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home Wife</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles Witzel</u>				14. MOTHER'S MAIDEN NAME <u>Anna D. Voelke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Edward G. Murphy 317 S Union Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive and arterial sclerotic</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular disease</u> DUE TO (c) <u>475.</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/24</u> , 19 <u>57</u> , to <u>8/1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/31</u> , 19 <u>57</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above. <u>8/1/57</u> ADDRESS (Street, city or town, state) <u>211 N. Union Ave</u> DATE SIGNED <u>8/1/57</u>							
ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D. <u>211 N. Union Ave</u>							
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D. Haire de Grace, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8/3/57</u>		<u>Mt. Eain</u>		<u>Harford Chase Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Franklin H. Chase, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>8-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis m.d.</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 5 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 221 10-23-57 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

08568

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>13 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford, Md.</u> d. STREET ADDRESS <u>1219 Freedom St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Berema Ridout Pinion</u> First Middle Last				4. DATE OF DEATH <u>8/28/57</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/8/1918</u> 39 yrs.	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		11. BIRTHPLACE (State or foreign country) <u>Bozman Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stephen Ridout</u>				14. MOTHER'S MAIDEN NAME <u>Delwa Brooks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Lawrence Pinion</u> Address <u>219 Freedom St. Harford Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cirrhosis of Liver</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6-7 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/2</u> , 19 <u>51</u> , to <u>8/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/28</u> , 19 <u>57</u> , and that death occurred at <u>9:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Stansbury</u>				ADDRESS (Street, city or town, state) <u>529 Revolution St. Harford Md.</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				DATE SIGNED <u>8/29/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8/31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bozman</u>		22d. LOCATION (City, town, or county) (State) <u>Bozman Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lawrence Pinion</u>				ADDRESS <u>Harford Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8-29-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

SEP 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

08561

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08569

Reg. Dist. No. 183

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAYRE DE GRACE</u>	c. LENGTH OF STAY IN 1b <u>TRANSIENT</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oct. 1 - Mues, N.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>70 X - 3</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>ROBERT</u> Last <u>POPE</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 26, 1931</u>
9. AGE (in years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Durham N.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>J.B. Pope</u>	
14. MOTHER'S MAIDEN NAME <u>Rwannie Richardson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>J.B. Pope</u> Address <u>Oct. 1 - Mues N.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHING INJURY CHEST, ABDOMEN</u> 824 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AND LOWER EXTREMITIES & COMPOUND</u> DUE TO (c) <u>COMMINUTED FRACTURE LT LEG</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>CRUSHED BETWEEN PARKED AND MOVING CAR</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:15 a.m. AUG 4 1957</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HIGHWAY</u>		20f. (City or town) (County) (State) <u>BELCAMP HARFORD MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Philip W. Hennessey</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Philip W. Hennessey</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/6/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Vernon</u>		22d. LOCATION (City, town, or county) (State) <u>White Co N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barry H. Sn. Howard</u>		24a. REC'D BY REGISTRAR <u>8-4-57</u>	
ADDRESS <u>Howard</u>		24b. REGISTRAR'S SIGNATURE <u>A. R. Remon M.D.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. OCCUPATION <i>Engineer</i>		5. MARITAL STATUS <i>Married</i>		6. PLACE OF BIRTH <i>Baltimore, Md.</i>	
7. DATE OF DEATH <i>Aug 5, 1957</i>		8. TIME OF DEATH <i>10:30 AM</i>		9. PLACE OF DEATH <i>Home</i>	
10. CAUSE OF DEATH <i>Myocardial Infarction</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF EXAMINER <i>[Signature]</i>	
13. SIGNATURE OF ATTENDING PHYSICIAN <i>[Signature]</i>		14. SIGNATURE OF CORONER <i>[Signature]</i>		15. SIGNATURE OF JURY <i>[Signature]</i>	
16. SIGNATURE OF WITNESS <i>[Signature]</i>		17. SIGNATURE OF WITNESS <i>[Signature]</i>		18. SIGNATURE OF WITNESS <i>[Signature]</i>	
19. SIGNATURE OF WITNESS <i>[Signature]</i>		20. SIGNATURE OF WITNESS <i>[Signature]</i>		21. SIGNATURE OF WITNESS <i>[Signature]</i>	
22. SIGNATURE OF WITNESS <i>[Signature]</i>		23. SIGNATURE OF WITNESS <i>[Signature]</i>		24. SIGNATURE OF WITNESS <i>[Signature]</i>	
25. SIGNATURE OF WITNESS <i>[Signature]</i>		26. SIGNATURE OF WITNESS <i>[Signature]</i>		27. SIGNATURE OF WITNESS <i>[Signature]</i>	
28. SIGNATURE OF WITNESS <i>[Signature]</i>		29. SIGNATURE OF WITNESS <i>[Signature]</i>		30. SIGNATURE OF WITNESS <i>[Signature]</i>	
31. SIGNATURE OF WITNESS <i>[Signature]</i>		32. SIGNATURE OF WITNESS <i>[Signature]</i>		33. SIGNATURE OF WITNESS <i>[Signature]</i>	
34. SIGNATURE OF WITNESS <i>[Signature]</i>		35. SIGNATURE OF WITNESS <i>[Signature]</i>		36. SIGNATURE OF WITNESS <i>[Signature]</i>	
37. SIGNATURE OF WITNESS <i>[Signature]</i>		38. SIGNATURE OF WITNESS <i>[Signature]</i>		39. SIGNATURE OF WITNESS <i>[Signature]</i>	
40. SIGNATURE OF WITNESS <i>[Signature]</i>		41. SIGNATURE OF WITNESS <i>[Signature]</i>		42. SIGNATURE OF WITNESS <i>[Signature]</i>	
43. SIGNATURE OF WITNESS <i>[Signature]</i>		44. SIGNATURE OF WITNESS <i>[Signature]</i>		45. SIGNATURE OF WITNESS <i>[Signature]</i>	
46. SIGNATURE OF WITNESS <i>[Signature]</i>		47. SIGNATURE OF WITNESS <i>[Signature]</i>		48. SIGNATURE OF WITNESS <i>[Signature]</i>	
49. SIGNATURE OF WITNESS <i>[Signature]</i>		50. SIGNATURE OF WITNESS <i>[Signature]</i>		51. SIGNATURE OF WITNESS <i>[Signature]</i>	
52. SIGNATURE OF WITNESS <i>[Signature]</i>		53. SIGNATURE OF WITNESS <i>[Signature]</i>		54. SIGNATURE OF WITNESS <i>[Signature]</i>	
55. SIGNATURE OF WITNESS <i>[Signature]</i>		56. SIGNATURE OF WITNESS <i>[Signature]</i>		57. SIGNATURE OF WITNESS <i>[Signature]</i>	
58. SIGNATURE OF WITNESS <i>[Signature]</i>		59. SIGNATURE OF WITNESS <i>[Signature]</i>		60. SIGNATURE OF WITNESS <i>[Signature]</i>	
61. SIGNATURE OF WITNESS <i>[Signature]</i>		62. SIGNATURE OF WITNESS <i>[Signature]</i>		63. SIGNATURE OF WITNESS <i>[Signature]</i>	
64. SIGNATURE OF WITNESS <i>[Signature]</i>		65. SIGNATURE OF WITNESS <i>[Signature]</i>		66. SIGNATURE OF WITNESS <i>[Signature]</i>	
67. SIGNATURE OF WITNESS <i>[Signature]</i>		68. SIGNATURE OF WITNESS <i>[Signature]</i>		69. SIGNATURE OF WITNESS <i>[Signature]</i>	
70. SIGNATURE OF WITNESS <i>[Signature]</i>		71. SIGNATURE OF WITNESS <i>[Signature]</i>		72. SIGNATURE OF WITNESS <i>[Signature]</i>	
73. SIGNATURE OF WITNESS <i>[Signature]</i>		74. SIGNATURE OF WITNESS <i>[Signature]</i>		75. SIGNATURE OF WITNESS <i>[Signature]</i>	
76. SIGNATURE OF WITNESS <i>[Signature]</i>		77. SIGNATURE OF WITNESS <i>[Signature]</i>		78. SIGNATURE OF WITNESS <i>[Signature]</i>	
79. SIGNATURE OF WITNESS <i>[Signature]</i>		80. SIGNATURE OF WITNESS <i>[Signature]</i>		81. SIGNATURE OF WITNESS <i>[Signature]</i>	
82. SIGNATURE OF WITNESS <i>[Signature]</i>		83. SIGNATURE OF WITNESS <i>[Signature]</i>		84. SIGNATURE OF WITNESS <i>[Signature]</i>	
85. SIGNATURE OF WITNESS <i>[Signature]</i>		86. SIGNATURE OF WITNESS <i>[Signature]</i>		87. SIGNATURE OF WITNESS <i>[Signature]</i>	
88. SIGNATURE OF WITNESS <i>[Signature]</i>		89. SIGNATURE OF WITNESS <i>[Signature]</i>		90. SIGNATURE OF WITNESS <i>[Signature]</i>	
91. SIGNATURE OF WITNESS <i>[Signature]</i>		92. SIGNATURE OF WITNESS <i>[Signature]</i>		93. SIGNATURE OF WITNESS <i>[Signature]</i>	
94. SIGNATURE OF WITNESS <i>[Signature]</i>		95. SIGNATURE OF WITNESS <i>[Signature]</i>		96. SIGNATURE OF WITNESS <i>[Signature]</i>	
97. SIGNATURE OF WITNESS <i>[Signature]</i>		98. SIGNATURE OF WITNESS <i>[Signature]</i>		99. SIGNATURE OF WITNESS <i>[Signature]</i>	
100. SIGNATURE OF WITNESS <i>[Signature]</i>		101. SIGNATURE OF WITNESS <i>[Signature]</i>		102. SIGNATURE OF WITNESS <i>[Signature]</i>	

RECEIVED
AUG 6 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

BALTIMORE, 18										08570		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										185		
Reg. Dist. No.												
1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Harford</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ostons Lane</u>					d. STREET ADDRESS <u>Ostons Lane</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Beverly G. Quickley</u>					4. DATE OF DEATH <u>August 25</u> 19 <u>57</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/15/1936</u>		9. AGE (in years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>					11. BIRTH PLACE (State or foreign country) <u>Prigman Md.</u>		
13. FATHER'S NAME <u>Charles J. Reunion</u>					14. MOTHER'S MAIDEN NAME <u>Beatrice Banks</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mrs. Charles J. Reunion</u> Address <u>Osborne Road Aberdeen, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending Toxicological Examination</u> <u>970.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Poisoning due to barbitual derivations (nembutal)</u> DUE TO (c) <u>(nembutal)</u>										INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Depressed & took bottle nembutal capsules</u>												
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
MEDICAL CERTIFICATION												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Depressed & took bottle nembutal capsules</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>8-25-57</u> 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Osbornes Lane Harford Aberdeen</u> (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .												
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>					22b. DATE THEREOF <u>8/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Swan Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Swan Creek Harf. Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Harold Chase</u> ADDRESS <u>Md.</u>					24a. REC'D BY REGISTRAR <u>8-26-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis m.d.</u>					

BUREAU V. 5

AUG 28 1957

RECEIVED

08562

CERTIFICATE OF DEATH

Reg. Dist. No. 186

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>17 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>71 HARFORD MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSHUA</u> Middle <u>ALBERT</u> Last <u>QUICKLEY</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1934</u>
9. AGE (In years lost birthday) <u>23</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aberdeen Proving Ground</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>JOSHUA QUICKLEY, SR.</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES POLSTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>216-30-8605</u>	
17. INFORMANT <u>BEVERLY QUICKLEY</u>		Address <u>ABERDEEN, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Fulminating Pneumonia (Bilateral)</u> <u>053.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) <u>Res. Staphylococcus Infection</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493x</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/30</u> , 19 <u>57</u> , to <u>8/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/2</u> , 19 <u>57</u> , and that death occurred at <u>11:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St., Harford Co., Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>8/3/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-6-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Bullock</u>		ADDRESS <u>Harford Co., Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 8-4-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08564

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08572

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford Grace</u>				c. LENGTH OF STAY IN 1b <u>1 hour</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Hartford Memorial Hospital</u>				d. STREET ADDRESS <u>31 Aberdeen</u>			
3. NAME OF DECEASED (Type or print) <u>Joseph Ray Roland</u>				4. DATE OF DEATH <u>August 21 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-10-38</u>	
9. AGE (in years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lock Joint Pipe Co Perryman Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Arnon Roland</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Arnon Roland, New Lexington, Md.</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture SKu II, compound</u> 9/10.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Compound fracture both bones R leg</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u> </u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pipe mold fell on him</u>			
20c. TIME OF INJURY Month, Day, Year <u>9 August 1957</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work or Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Lock Joint Pipe Co Perryman Md.</u>				20f. (City or town) (County) (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Donald C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerold C Palmer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/24/57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Buath</u>				22d. LOCATION (City, town, or county) (State) <u>Garrison N.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>George H. Howard</u>				ADDRESS <u> </u>			
24a. REC'D BY REGISTRAR <u> </u>				24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>			
DATE <u>8-22-57</u>							

MEDICAL CERTIFICATION

99

I

12

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

BUREAU V. 5

AUG 23 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08574

CERTIFICATE OF DEATH

08573

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Darlington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Darlington (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS— Route #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rose Middle Belle Last Smith				4. DATE OF DEATH Month August Day 23 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 August 1870		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Hanikson				14. MOTHER'S MAIDEN NAME Harriett Hillis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no., or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Nathan D. Smith Jr.		Address Darlington, Md. Route #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Acute Congestive Heart Failure DUE TO (b) Generalized Atherosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH Immed 5-8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 1956, to August 23 , 1957, that I last saw the deceased alive on August 22 , 1957, and that death occurred at 4:00 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Dudley Phillips		M.D. Darlington, Md.		ADDRESS (Street, city or town, state)		DATE SIGNED 8/24/57	
PHYSICIAN'S NAME (Type) Dudley Phillips		M.D. Darlington, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/26/57		22c. NAME OF CEMETERY OR CREMATORY Camptown Memorial		22d. LOCATION (City, town, or county) (State) Camptown, Bradford Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Herring Aberdeen Maryland				24a. REC'D BY REGISTRAR Aug 26/57		24b. REGISTRAR'S SIGNATURE Mellie K. Perry	

CERTIFICATE OF DEATH

10374

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957

BUREAU V. S.

JUG 27 1957

RECEIVED

NAME OF DECEASED [Illegible]		DATE OF DEATH [Illegible]	
AGE [Illegible]		SEX [Illegible]	
RACE [Illegible]		EDUCATION [Illegible]	
MARRIAGE [Illegible]		OCCUPATION [Illegible]	
PLACE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
DATE OF BIRTH [Illegible]		DATE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		SIGNATURE OF DECEASED [Illegible]	
SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF JUDGE [Illegible]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08574

08565

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford Chase c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Hart. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace d. STREET ADDRESS 1 Congress e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUSSELL Middle Revel Last STROHM		4. DATE OF DEATH Month August Day 7 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/1907
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min.	IF UNDER 24 HRS. Months 50 Days 50 Hours 50 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber Shop	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Strohm		14. MOTHER'S MAIDEN NAME Salitha Jane Hatfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Short Funeral Home, Mr. Carmel Ill.		Address Mr. Carmel Ill.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/8/57	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Funeral		22b. DATE THEREOF 8/9/57	
22c. NAME OF CEMETERY OR CREMATORY Mr. Carmel		22d. LOCATION (City, town, or county) (State) Mr. Carmel Ill.	
23. FUNERAL DIRECTOR'S SIGNATURE Sam. Harford Chase Md.		ADDRESS Sam. Harford Chase Md.	
24a. REC'D BY REGISTRAR 8-9-57		24b. REGISTRAR'S SIGNATURE A. L. Lewis M.D.	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

AUG 12 1957

RECEIVED

08575
CERTIFICATE OF DEATH

Reg. Dist. No.

18

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin RD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Baldwin RD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS —			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harriet D Striker</u>				4. DATE OF DEATH Month Day Year <u>Aug 28 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 6 1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Daniels</u>				14. MOTHER'S MAIDEN NAME —			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. —		17. INFORMANT Address <u>G E Striker, Baldwin MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vremia</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —						INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>3 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1952</u> to <u>present</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 28</u> , 19 <u>57</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest C. Brown Jr. M.D.</u>				ADDRESS (Street, city or town, state) <u>1101 N. Calvert St</u>		DATE SIGNED <u>Aug 27, 57</u>	
PHYSICIAN'S NAME (Type) —							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St James</u>		22d. LOCATION (City, town, or county) (State) <u>THORNTON MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion E. K. Garrett</u>				24a. REC'D BY REGISTRAR <u>SEP 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frederick J. Brown</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

[Faint bleed-through text from the reverse side of the page is visible through the paper.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 08566 08576 Reg. Dist. No. 185 08566 CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE BRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>131 N. PHILADELPHIA BLVD</u>			
3. NAME OF DECEASED (Type or print) First <u>CHARLOTTE</u> Middle <u>ANN</u> Last <u>STYER</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 Aug. 1901</u>	9. AGE (In years lost birthday) <u>55</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Luther S. McCardell</u>				14. MOTHER'S MAIDEN NAME <u>Cathrine R. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>131 N. Phila</u>			
				Evelyn M. McFadden Aberdeen, Md. Blvd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>56</u> , to <u>Aug 11</u> , 19 <u>57</u> , that I lost the deceased alive on <u>Aug 11</u> , 19 <u>57</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. J. Plunkett Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Aberdeen, Md.</u>		DATE SIGNED <u>8-11-57</u>	
PHYSICIAN'S NAME (Type) <u>B. J. Plunkett Jr.</u>				ADDRESS <u>Aberdeen, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. 2 Aberdeen, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Herring</u> ADDRESS <u>Aberdeen Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>8-13-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis m.d.</u>	

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Havre de Grace	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1 608 Revolution Street	
3. NAME OF DECEASED (Type or print) First John Middle William Last Thompson		4. DATE OF DEATH Month August Day 29 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 March 1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. APG., Md.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Thompson		14. MOTHER'S MAIDEN NAME Susie E. Cullum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-18-6442	
17. INFORMANT LOUISE MITCHELL-HAVRE DE GRACE Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO (b) METASTATIC CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PROSTATIC CARCINOMA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 YR.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/11 1957 to 8/29 1957 that I last saw the deceased alive on 8/28 1957 , and that death occurred at 5:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 N. UNION AVE DATE SIGNED 9-1-57			
ACTUAL SIGNATURE Irwin Randall Ross M.D. IRWIN RANDALL ROSS HAVRE DE GRACE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/2/57	22c. NAME OF CEMETERY OR CREMATORY Calvary	22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John G. [Signature]		24a. REC'D BY REGISTRAR DATE 9-3-57	24b. REGISTRAR'S SIGNATURE A. R. Remison

SALE - 50% OFF

BUREAU V. S.

SEP 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08576

CERTIFICATE OF DEATH

08578

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, R.D.,				c. LENGTH OF STAY IN 1b 6 wks.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle A. Last Wells				4. DATE OF DEATH Month Aug. Day 16 Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1873	9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Penna.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Montgomery				14. MOTHER'S MAIDEN NAME Mary E. Garrett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Laban Wells, Baltimore 22 Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) old age 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - Generalized DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.9 Fractured Left Hip						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)			
21. I certify that I attended the deceased from June 2, 1957 , to Aug 16, 1957 , that I last saw the deceased alive on Aug 10, 1957 , and that death occurred at 12:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dudley Phillips M.D.		ADDRESS (Street, city or town, state) Darlington Md.		DATE SIGNED Aug 21 1957			
PHYSICIAN'S NAME (Type) Dudley Phillips		Darlington Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 18, 1957	22c. NAME OF CEMETERY OR CREMATORY Camp Chapel	22d. LOCATION (City, town, or county) (State) White Marsh, Balto., Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McCombs Jr.		ADDRESS Abingdon, Md.		24a. REC'D BY REGISTRAR Aug 21 1957	24b. REGISTRAR'S SIGNATURE Trusella Howard		

BUREAU V. S.

AUG 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08579-

08568

CERTIFICATE OF DEATH

Reg. Dist. No. 186-

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harrode-Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		d. STREET ADDRESS 07 x 02	
3. NAME OF DECEASED (Type or print) First Mary Middle Francis Last Whitaker		4. DATE OF DEATH Month 8 Day 2 Year 1957	
5. SEX Female	6. COLOR OR RACE white	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/21/69
9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham HASSON		14. MOTHER'S MAIDEN NAME SARAH KELLY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Clarence Whitaker.	
17. INFORMANT Address Clarence Whitaker.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 640.0 DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 260x Diabetes			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 10, 1957 to Aug 2, 1957 , that I last saw the deceased alive on Aug 2, 1957 , and that death occurred at 11 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence I. Benson M.D.		ADDRESS (Street, city or town, state) Port Deposit, Md. DATE SIGNED Aug 2-1957	
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/5/57	22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery	22d. LOCATION (City, town, or county) (State) Port Deposit, RD, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Keara Patterson-Song ADDRESS Box 188, Perryville, Md.		24a. REC'D BY REGISTRAR 8-4-57	24b. REGISTRAR'S SIGNATURE A. L. Lewis M.D.

BUREAU V. 8

Aug 6 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 182

08569

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel-Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington x 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R. F. D. # 1</u>				d. STREET ADDRESS <u>R. F. D. # 1</u>			
3. NAME OF DECEASED (Type or print) <u>E. L. Lish</u> First Middle Last				4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-5-1871</u>	
				9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handy man</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Harford County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>George White</u>				14. MOTHER'S MAIDEN NAME <u>Maria</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Effie Downey - Bel-Air, Md.</u> Address <u>R. F. D. # 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Prostatism with Urinary Retention</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/12</u> 19 <u>57</u> , to <u>8/7</u> 19 <u>57</u> , that I last saw the deceased alive on <u>8/7</u> 19 <u>57</u> , and that death occurred at <u>11:00 P. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George J. Stansbury</u>				ADDRESS (Street, city or town, state) <u>509 Revolution St., Havre de Grace, Md.</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				DATE SIGNED <u>8/8/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-10-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clark's Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Kalmar, Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia L. Bullenk-Havre de Grace</u>				ADDRESS <u>U. S. A.</u>		24a. REC'D BY REGISTRAR <u>8-8-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Prueville four road</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5. BUREAU V.

AUG 12 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

08577

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 182

08581

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STREET</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOME STREET, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>D.</u> Last <u>WILSON SR</u>		d. STREET ADDRESS <u>1</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month <u>AUGUST</u> Day <u>29</u> Year <u>19 57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMMUEL WILSON</u>		14. MOTHER'S MAIDEN NAME <u>JANE MARY DAVIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>SON</u> <u>WIFE</u> <u>SAME</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>---</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>---</u> a. m. <u>---</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Philip W. Heuman</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>---</u>		22b. DATE THEREOF <u>Aug 31/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>---</u>		22d. LOCATION (City, town, or county) (State) <u>---</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hoff</u>		24a. REC'D BY REGISTRAR DATE <u>8-31-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Phyllis Toward</u>			

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		9-4-68		MEMPHIS, TENN.	
RESIDENCE		BIRTHPLACE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENN.		MEMPHIS, TENN.		HIGH SCHOOL		ATTORNEY		HEART DISEASE		SUICIDE	
DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		TEMPERATURE		PULSE	
9-4-68		9-4-68		10:00 AM		10:00 AM		98.6		60	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		SIGNATURE OF WITNESS		TITLE OF WITNESS		SIGNATURE OF JURY		TITLE OF JURY	
JAMES EARL RAY		MEDICAL EXAMINER		JAMES EARL RAY		ATTORNEY		JAMES EARL RAY		JURY	
DATE OF EXAMINATION		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
9-4-68		9-4-68		9-4-68		9-4-68		9-4-68		9-4-68	

BUREAU V. S.

SEP 4 1968

RECEIVED